



Short-Term Disability Claim Form

Mutual of Omaha Insurance Company
 United of Omaha Life Insurance Company
 Group Insurance Claims Management
 Mutual of Omaha Plaza Omaha, NE 68175 – 0001
 Phone 800-877-5176 Fax 402-997-1865

Section I – Employee Statement (Answer all questions to avoid delay)

Current Employer's Name Blue Mountain Production Company	Group ID Number G0000ARAF	Job Title Lab Technician	Hours Worked Per Week 40
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Name
James Benny Jackson

Address [REDACTED]	City Ripley	State MS	Zip 38663
(Area Code) Home Telephone Number [REDACTED]	(Area Code) Cellular Telephone Number [REDACTED]	Social Security Number [REDACTED]	
Date of Birth 06/04/1953	Height 6'2"	Weight 250	Dominant Hand: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Right <input type="checkbox"/> Left
		<input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Disability (1st Day Absent) 04/27/2015		Date First Treated 04/27/2015	
Estimated return to work date Not known			

Nature of illness and when symptoms first appeared, or describe how and where accident occurred.

Chronic cough & shortness of breath.

Was the disability work related? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Have you filed a Workers' Compensation claim? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
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Was disability related to a motor vehicle accident or is another third party liable? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Physician's Name Micheal D. Wilons, MD
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Other income you have filed for, are receiving, or are eligible for:

	Amount	Date Claim Filed	Date Benefits Began
Workers' Compensation	\$ N/A		
State Disability	\$ [REDACTED]		
Other	\$ [REDACTED]		

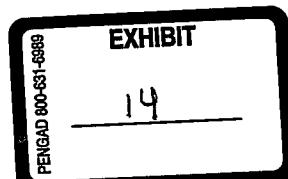
Important Notice: If you are age 60 or over, please contact your employer within 31 days of disability to preserve your group life insurance conversion privileges

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee's Signature: _____

Date 5-5-15

MUG6110A_032910



Page 1 of 6

Form continued on Page 2

Exhibit "14"

DFTS 000002

FAX NUMBER (402) 997-1865

Form must be completed in full at no expense to Mutual of Omaha

Page 2 of 6

Authorization to Disclose Health Information to my Employer

I authorize Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to disclose health information about me to my employer, and to my employer's broker. I understand that my employer, and its broker, will use this information to monitor and manage the disability benefits program provided under my Group Disability policy. I also understand that my employer and its broker will use the information solely for the purposes of auditing disability benefits paid, providing claims assistance, determining waiver or discontinuance of premium deductions, and coordinating with other subsidized salary continuance plans my employer may offer.

The health information that may be disclosed pursuant to this authorization includes such items as medical history, mental and physical condition, prescription drug records and alcohol or drug use.

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, my claim for benefits may not be paid.

This authorization is valid for 24 months from the date I sign it. I understand that I may revoke this authorization at any time. If I would like to revoke this authorization, I should send my revocation request to:

ATTN: Group Insurance Claims Management
 Mutual of Omaha Insurance Company / United of Omaha Life Insurance Company
 Mutual of Omaha Plaza
 Omaha, NE 68175-0001

Or

Fax: 402-997-1865

I also understand that any revocation of this authorization will not affect any use or disclosure of health information that occurred prior to receipt of my revocation.

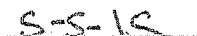
I understand that I am entitled to receive a copy of this authorization.

James Benny Jackson, [REDACTED], Ripley, MS 38663

(Printed Name and Address)



(Signature)



(Date)

OR

If applicable: I am the legal representative of the person whose financial and health information is to be disclosed, and I am authorized to grant permission on behalf of that person.

Printed Name of Legal Representative: _____

(Signature of Legal Representative)

(Type of Legal Rep.)

(Date)

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Page 2 of 6

Continued on page 3

DFTS 000003

Authorization to Disclose Personal Information

Personal information includes medical history, mental and physical condition, prescription drug records, alcohol or drug use, financial and occupational information.

I authorize any physician, medical or dental practitioner, hospital, clinic, pharmacy benefit manager, other medical care facility, health maintenance organization, insurer, employer, consumer reporting agency and any other provider of medical or dental services to release records containing the personal information of:

Claimant/Patient Name: James Benny Jackson

I authorize personal information to be faxed or mailed to:

Fax: 402-997-1865

Group Insurance Claims Management
 Mutual of Omaha Insurance Company/United of Omaha Life Insurance Company
 Mutual of Omaha Plaza
 Omaha, NE 68175-0001

I understand that the personal information disclosed will be used by Mutual of Omaha Insurance Company and United of Omaha Life Insurance Company to evaluate my claim for disability benefit plan reimbursement and that if I refuse to sign this authorization my claim for benefits may not be paid.

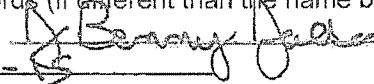
I understand that if the person or entity to whom information is disclosed is not a health care provider or health plan subject to federal privacy regulations, such personal information may be re-disclosed without the protection of the federal privacy regulations.

I understand that this authorization will expire 24 months after the date signed.

I understand that I may revoke this authorization at any time by faxing or mailing a request to Mutual of Omaha Insurance Company and United of Omaha Life Insurance using the contact information provided above. If I revoke this authorization, it will not affect any use or disclosure of personal information that occurred prior to the receipt of my revocation.

I understand that I am entitled to receive a copy of this authorization and that a copy is as valid as the original.

Name(s) used for records (if different than the name below):

Signature of Claimant: 

Date Signed: 5-5-08

If Applicable: I am the legal representative of the claimant and I am authorized to grant permission on behalf of the claimant.

Printed name of Legal Representative:

Signature of Legal Representative:

Type of Legal Representative:

THIS AUTHORIZATION COMPLIES WITH HIPAA AND OTHER FEDERAL AND STATE LAWS

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Page 4 of 6

Company Name Blue Mountain Production Company		Group ID Number G0000ARAF	Master Policy Number
Class No. or Description		Division / Location No. or Description	
Address 31 CR 827	City Blue Mountain	State MS	Zip 38663
Email Address rhonda.barnes@oildri.com			
Employee's Name: James Benny Jackson			
Weekly earnings as defined by the Plan: \$285.00 (Please note: Benefits will be calculated based on premium received.)		Number of weekly hours worked: 40	
Was disability caused by employment? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		Has workers' compensation claim been filed? <input checked="" type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Does the employee contribute toward the premium? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what percent is paid by the employee? _____ % Pre-tax _____ Post-tax _____ ?			
Employee's payroll classification (circle one) <input type="checkbox"/> Exempt <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Salaried <input checked="" type="checkbox"/> Hourly <input type="checkbox"/> Union <input type="checkbox"/> Non-Union <input type="checkbox"/> Other			
How was the employee paid?			
Is this employee eligible for salary continuation / sick leave? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is the weekly amount? \$ _____			
When do benefits begin? _____ End? _____			
Date of Hire: 02/20/2000		Date Covered Under This Plan: 4/20/2000	
Does Mutual of Omaha cover the employee for group long-term disability? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
Does United of Omaha Life Insurance Company cover the employee for group life? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If so, please complete the following			
Name of employee's beneficiary according to your records: Wanda Jackson		Relationship to employee: Spouse	
Important Notice: For employees age 60 or over, refer to the policy provisions regarding group life continuation and conversion rights.			
Please contact employee's direct supervisor and then circle the strength demand below which best describes the employee's job:			
Circle One	S – Sedentary	10 lbs. Maximum lifting, occasional lift/carry of small articles. Some occasional walking or standing may be required.	
	L – Light	20 lbs. Maximum lifting with frequent lift/carry up to 10 lbs. A job is light if less lifting is involved but significant walking/standing is done or if done mostly sitting but requires push/pull on arm or leg controls.	
	M – Medium	50 lbs. Maximum lifting with frequent lift/carry up to 25 lbs	
	H – Heavy	100 lbs. Maximum lifting with frequent lift/carry up to 50 lbs	
	V – Very Heavy	Over 100 lbs. Lifting with frequent lift/carry over 50 lbs.	
Employee's Job Title Lab Technician		Last Day at Work 04/23/15	
What was the employee's employment status on the first day absent? Active			
Description of major job duties – Please attach job description		Has the employee returned to work? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No a) If yes, when? b) If not, what is the estimated return to work date?	
Packaging Job includes all duties for Lab Technician.			
Can the employee's job be modified? <input type="checkbox"/> Yes <input type="checkbox"/> No		Title of Person Completing Claim Form Human Resources Coordinator	
Signature of Person Completing Claim Form <i>Rhonda Barnes</i>		Email Address rhonda.barnes@oildri.com	
Date Signed <i>5/5/15</i>	(Area Code) Phone Number (662)685-4386 ext.5002	(Area Code) Fax Number (662)685-4341/(662)837-3027	

Please notify us if the Employee returns to work after the submission of this form.

From:

05/13/2015 11:49

#914 P.006/007

05/05/2015 08:34 6626854386

BLUE MOUNTAIN PRODUC

PAGE 12

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Page 5 of 6

Section 3 - Attending Physician's Statement (Answer all questions to avoid delay)

Employer Name		Group ID Number
Name of Patient (Last, First, MI) - Please Print <u>Jackson James Benny</u>		Date of Birth <u>6-4-53</u>
Diagnoses <u>Polyt infection bronchospasm, bronchospastic rarely</u>		ICD-9 Code(s) <u>519.11 519.19</u>
Symptoms <u>Cough, congestion shortness of breath, wheeze</u>		Date symptom first appeared <u>Dec. 2014</u>
Initial date of treatment <u>4/27/2015</u>	Last date of treatment <u>4/27/2015</u>	Next date of treatment / office visit <u>5/27/15</u>
Is disability due to: <input checked="" type="checkbox"/> Accident / Injury <input type="checkbox"/> Sickness		Is the disability work related? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
If applicable, list the surgical procedure(s) - Describe fully and provide dates if any.		

If disability is due to Pregnancy, please provide the information below.

Date of Last Monthly Period	Expected Date of Delivery	Expected Type of Delivery Vaginal <input type="checkbox"/> Cesarean Section <input type="checkbox"/>
Actual Date of Delivery	Actual Type of Delivery Vaginal <input type="checkbox"/> Cesarean Section <input type="checkbox"/>	

If any of the following questions are answered "Yes," then please provide the information to the right of that question.

Was the patient treated in an Emergency Room? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date treated <u>4/27</u>	Name of Hospital	Name of Physician
Did another physician treat the patient? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date treated <u>4/27</u>	Physician's Name and Address <u>Medical Wilkins MD</u>	Memphis Lung Physicians Foundation
Was the patient hospital confined? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Dates Confined in Hospital: From <u></u> To <u></u>	Name of Hospital	<u>6025 Waller St. Suite 500</u>
Did patient have outpatient surgery in a hospital or ambulatory surgical center? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Date of surgery	Name of Facility	<u>MEC 36/20</u>

Functional Limitations - Abilities

Indicate frequency per day the listed activity can be performed. (n = never; o = occasional; c = constant)		Indicate longest single time durations each activity can be performed	
Lifting	Carrying	Sitting	Kneeling
1-5 lbs.	1-5 lbs.	Total time on feet	
6-10 lbs.	6-10 lbs.	Standing	Inside
11-25 lbs.	11-25 lbs.	Walking	
26-50 lbs.	26-50 lbs.	Bending	Outside Working with Others
51-100 lbs.	51-100 lbs.	Squatting	
Over 100 lbs.	Over 100 lbs.	Stooping	Other (explain)

R: Finger Dexterity
L: Finger Dexterity
R: Below Shoulder
L: Below Shoulder
R: Above Shoulders
L: Above Shoulders

Reaching

Has patient been issued Breathing in Work Environment
Please notify us if the employee returns to work after the submission of this form.

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Receiving his oxygen tank Central where
has failed & the white company

Page 5 of 6

Form continued on Page 6

DFTS 000006

From:

05/13/2015 11:49 #914 P.007/007

05/06/2015 08:34 6626654386

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PAGE 13

FAX NUMBER (402) 997-1868

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Page 6 of 6

Mutual Life Abilities - Abilities			
	Excellent	Good	Fair
Guarded			
Judgment / decision making			
Deal with work stresses			
Function independently			
Concentration / Attention span			
Emotional liability			
Caring for self / family			
Estimate overall prognosis			
The patient has been continuously disabled (unable to work) from _____ to _____			
Is the patient able to work with job modifications? <input type="checkbox"/> Yes <input type="checkbox"/> No			

The patient should be able to work full-time / part-time on _____, or a specific date is unavailable, in 1 month, 1 to 3 months, 3 to 6 months, or Other (please specify)

Remarks and/or treatment plan

If return of illness when returning to work, please list
any further time out of work environment

Name of the Attending Physician - Please Print Dr Mike Williams	Specialty / Degree(s) Pulmonary	Tax Identification Number
Address (No., Street, City, State, Zip) 6035 Walnut Grove Memphis, TN 38120	(Area Code) Telephone Number 901-767-5864	(Area Code) Fax Number 901-767-6591

If necessary, whom can we contact at the attending physician's office for additional information?

Name:

(Area Code) Telephone Number:

Signature of the Attending Physician:

Date

Please notify us if the Employee returns to work after the submission of this form.